Assembly Bill No. 113

Passed the Assembly April 7, 2011

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Chief Clerk of the Assembly

Passed the Senate April 7, 2011

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Secretary of the Senate

This bill was received by the Governor this _____ day of _____, 2011, at _____ o'clock ___M.

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Private Secretary of the Governor

CHAPTER _____

An act to amend Section 14163 of, and to add Article 5.17 (commencing with Section 14165.55) to, the Welfare and Institutions Code, relating to health, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 113, Monning. Health: hospitals: Medi-Cal.

Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which basic health care services are provided to qualified low-income persons. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions. Existing law establishes the continuously appropriated Health Care Deposit Fund from which expenditures of state, county, and federal funds for health care and administration under the Medi-Cal program are made as specified. Existing law authorizes the department to accept any elective transfer of funds from a county, political subdivision, or other governmental entity, and provides the department with the discretion of whether or not to deposit the transferred funds into the Medi-Cal Inpatient Payment Adjustment Fund, which is continuously appropriated and consists of moneys transferred to the fund to be used as the nonfederal share of payment adjustments made to hospitals under the Medi-Cal program.

This bill would require the department to establish, implement, and maintain the Nondesignated Public Hospital Intergovernmental Transfer Program, as specified, to assist nondesignated public hospitals in achieving federal financial participation to the fullest extent permitted by federal law. This bill would provide that a transferring entity, as defined, may agree to transfer its intergovernmental transfer allocation, as defined, to the state in accordance with the program and would require the state to deposit the transferred funds into the Medi-Cal Inpatient Payment Adjustment Fund. This bill would require funds transferred into the Medi-Cal Inpatient Payment Adjustment Fund to be, in part, transferred to the Health Care Deposit Fund for specified purposes.

By increasing the amount of moneys that may be deposited into the Medi-Cal Inpatient Payment Adjustment Fund and the Health Care Deposit Fund, and by revising the purposes for which moneys in those funds shall be used, this bill would make an appropriation. This bill would authorize the state to retain 9% of each intergovernmental transfer amount to reimburse the department, or to transfer to the General Fund, for the administrative costs of operating the program and for the benefit of Medi-Cal children's health programs.

This bill would appropriate $1,500,000,000 from the Hospital Quality Assurance Revenue Fund and $1,500,000,000 from the Federal Trust Fund to the department to be available for expenditure for specified purposes until January 1, 2014.

This bill would become operative only if SB 90 of the 2011–12 Regular Session of the Legislature is enacted.

This bill would declare that it is to take effect immediately as an urgency statute.

Appropriation: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 14163 of the Welfare and Institutions Code is amended to read:

14163. (a) For purposes of this section, the following definitions shall apply:

(1) "Public entity" means a county, a city, a city and county, the State of California, the University of California, a local health care district, a local health authority, or any other political subdivision of the state.

(2) "Hospital" means a health facility that is licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code to provide acute inpatient hospital services, and includes all components of the facility.

(3) "Disproportionate share hospital" means a hospital providing acute inpatient services to Medi-Cal beneficiaries that meets the criteria for disproportionate share status relating to acute inpatient services set forth in Section 14105.98.

(4) "Disproportionate share list" means the annual list of disproportionate share hospitals for acute inpatient services issued by the department pursuant to Section 14105.98.

(5) "Fund" means the Medi-Cal Inpatient Payment Adjustment Fund.

(6) "Eligible hospital" means, for a particular state fiscal year, a hospital on the disproportionate share list that is eligible to receive payment adjustment amounts under Section 14105.98 with respect to that state fiscal year.

(7) "Transfer year" means the particular state fiscal year during which, or with respect to which, public entities are required by this section to make an intergovernmental transfer of funds to the Controller.

(8) "Transferor entity" means a public entity that, with respect to a particular transfer year, is required by this section to make an intergovernmental transfer of funds to the Controller.

(9) "Transfer amount" means an amount of intergovernmental transfer of funds that this section requires for a particular transferor entity with respect to a particular transfer year.

(10) "Intergovernmental transfer" means a transfer of funds from a public entity to the state that is local government financial participation in Medi-Cal pursuant to the terms of this section.

(11) "Licensee" means an entity that has been issued a license to operate a hospital by the department.

(12) "Annualized Medi-Cal inpatient paid days" means the total number of Medi-Cal acute inpatient hospital days, regardless of dates of service, for which payment was made by or on behalf of the department to a hospital, under present or previous ownership, during the most recent calendar year ending prior to the beginning of a particular transfer year, including all Medi-Cal acute inpatient covered days of care for hospitals that are paid on a different basis than per diem payments.

(13) "Medi-Cal acute inpatient hospital day" means any acute inpatient day of service attributable to patients who, for those days, were eligible for medical assistance under the California state plan, including any day of service that is reimbursed on a basis other than per diem payments.

(14) "OBRA 1993 payment limitation" means the hospital-specific limitation on the total annual amount of payment adjustments to each eligible hospital under the payment adjustment program that can be made with federal financial participation under Section 1396r-4(g) of Title 42 of the United States Code as implemented pursuant to the Medi-Cal State Plan.

(b) The Medi-Cal Inpatient Payment Adjustment Fund is hereby created in the State Treasury. Notwithstanding Section 13340 of the Government Code, the fund shall be continuously appropriated to, and under the administrative control of, the department for the purposes specified in subdivision (d). The fund shall consist of the following:

(1) Transfer amounts collected by the Controller under this section, whether submitted by transferor entities pursuant to applicable provisions of this section or obtained by offset pursuant to subdivision (j).

(2) Any other intergovernmental transfers deposited in the fund, as permitted by Section 14164 or Article 5.17 (commencing with Section 14165.55).

(3) Any interest that accrues with respect to amounts in the fund.

(c) Moneys in the fund, which shall not consist of any state general funds, shall be used as the source for the nonfederal share of payments to hospitals pursuant to Section 14105.98. Moneys shall be allocated from the fund by the department and matched by federal funds in accordance with customary Medi-Cal accounting procedures, and used to make payments pursuant to Section 14105.98.

(d) Except as otherwise provided in Section 14105.98 or in any law appropriating a specified sum of money to the department for administering this section and Section 14105.98, moneys in the fund shall be used only for the following:

(1) Payments to hospitals pursuant to Section 14105.98.

(2) Transfers to the Health Care Deposit Fund as follows:

(A) In the amount of two hundred thirty-nine million seven hundred fifty-seven thousand six hundred ninety dollars ($239,757,690) for the 1994–95 and 1995–96 fiscal years.

(B) In the amount of two hundred twenty-nine million seven hundred fifty-seven thousand six hundred ninety dollars ($229,757,690) for the 1996–97 fiscal year.

(C) In the amount of one hundred fifty-four million seven hundred fifty-seven thousand six hundred ninety dollars ($154,757,690) for the 1997–98 fiscal year.

(D) In the amount of one hundred fourteen million seven hundred fifty-seven thousand six hundred ninety dollars ($114,757,690) for the 1998–99 fiscal year.

(E) (i) In the amount of eighty-four million seven hundred fifty-seven thousand six hundred ninety dollars ($84,757,690) for the 1999–2000 fiscal year.

(ii) It is the intent of the Legislature that the economic benefit of any reduction in the amount transferred, or to be transferred, to the Health Care Deposit Fund pursuant to this subdivision for the 1999–2000 fiscal year, as compared to the amount so transferred for the 1998–99 fiscal year, be allocated equally between public and nonpublic disproportionate share hospitals. To implement the reduction in clause (i) the department shall, by June 30, 2000, adjust the calculations in Section 14105.98 in order to allocate the funds in accordance with this clause.

(F) In the amount of twenty-nine million seven hundred fifty-seven thousand six hundred ninety dollars ($29,757,690) for the 2000–01 fiscal year and the 2001–02 fiscal year.

(G) In the amount of eighty-five million dollars ($85,000,000) for the 2002–03 fiscal year and each fiscal year thereafter.

(H) The transfers from the fund shall be made in six equal monthly installments to the Medi-Cal local assistance appropriation item (Item 4260-101-0001 of Section 2.00 of the annual Budget Act) in support of Medi-Cal expenditures. The first installment shall accrue in October of each transfer year, and all other installments shall accrue monthly thereafter from November through March.

(3) Transfers to the Health Care Deposit Fund for purposes set forth in Article 5.17 (commencing with Section 14165.55).

(e) For the 1991–92 state fiscal year, the department shall determine, no later than 70 days after the enactment of this section, the transferor entities for the 1991–92 transfer year. To make this determination, the department shall utilize the disproportionate share list for the 1991–92 fiscal year issued by the department pursuant to paragraph (1) of subdivision (f) of Section 14105.98. The department shall identify each eligible hospital on the list for which a public entity is the licensee as of July 1, 1991. The public entity that is the licensee of each identified eligible hospital shall be a transferor entity for the 1991–92 transfer year.

(f) The department shall determine, no later than 70 days after the enactment of this section, the transfer amounts for the 1991–92 transfer year.

The transfer amounts shall be determined as follows:

(1) The eligible hospitals for 1991–92 shall be identified. For each hospital, the applicable total per diem payment adjustment amount under Section 14105.98 for the 1991–92 transfer year shall be computed. This amount shall be multiplied by 80 percent of the eligible hospital's annualized Medi-Cal inpatient paid days as determined from all Medi-Cal paid claims records available through April 1, 1991. The products of these calculations for all eligible hospitals shall be added together to determine an aggregate sum for the 1991–92 transfer year.

(2) The eligible hospitals for 1991–92 involving transferor entities as licensees shall be identified. For each hospital, the applicable total per diem payment adjustment amount under Section 14105.98 for the 1991–92 transfer year shall be computed. This amount shall be multiplied by 80 percent of the eligible hospital's annualized Medi-Cal inpatient paid days as determined from all Medi-Cal paid claims records available through April 1, 1991. The products of these calculations for all eligible hospitals with transferor entities as licensees shall be added together to determine an aggregate sum for the 1991–92 transfer year.

(3) The aggregate sum determined under paragraph (1) shall be divided by the aggregate sum determined under paragraph (2), yielding a factor to be utilized in paragraph (4).

(4) The factor determined in paragraph (3) shall be multiplied by the amount determined for each hospital under paragraph (2). The product of this calculation for each hospital in paragraph (2) shall be divided by 1.771, yielding a transfer amount for the particular transferor entity for the transfer year.

(g) For the 1991–92 transfer year, the department shall notify each transferor entity in writing of its applicable transfer amount or amounts.

(h) For the 1992–93 transfer year and subsequent transfer years, transfer amounts shall be determined in the same procedural manner as set forth in subdivision (f), except:

(1) The department shall use all of the following:

(A) The disproportionate share list applicable to the particular transfer year to determine the eligible hospitals.

(B) The payment adjustment amounts calculated under Section 14105.98 for the particular transfer year. These amounts shall take into account any projected or actual increases or decreases in the size of the payment adjustment program as are required under

Section 14105.98 for the particular year in question, including any decreases resulting from the application of the OBRA 1993 payment limitation. The department may issue interim, revised, and supplemental transfer requests as necessary and appropriate to address changes in payment adjustment levels that occur under Section 14105.98. All transfer requests, or adjustments thereto, issued to transferor entities by the department shall meet the requirements set forth in subdivision (i).

(C) Data regarding annualized Medi-Cal inpatient paid days for the most recent calendar year ending prior to the beginning of the particular transfer year, as determined from all Medi-Cal paid claims records available through April 1 preceding the particular transfer year.

(D) The status of public entities as licensees of eligible hospitals as of July 1 of the particular transfer year.

(E) For the 1993–94 transfer year and subsequent transfer years, the divisor to be used for purposes of the calculation referred to in paragraph (4) of subdivision (f) shall be determined by the department. The divisor shall be calculated to ensure that the appropriate amount of transfers from transferor entities are received into the fund to satisfy the requirements of Section 14105.98, exclusive of the amounts described in paragraph (2) of this subdivision, and to satisfy the requirements of paragraph (2) of subdivision (d), for the particular transfer year. For the 1993–94 transfer year, the divisor shall be 1.742.

(F) The following provisions shall apply for certain transfer amounts relating to nonsupplemental payments under Section 14105.98:

(i) For the 1998–99 transfer year, transfer amounts shall be determined as though the payment adjustment amounts arising pursuant to subdivision (ag) of Section 14105.98 were increased by the amounts paid or payable pursuant to subdivision (af) of Section 14105.98.

(ii) Any transfer amounts paid by a transferor entity pursuant to subparagraph (C) of paragraph (2) shall serve as credit for the particular transferor entity against an equal amount of its transfer obligation for the 1998–99 transfer year.

(iii) For the 1999–2000 transfer year, transfer amounts shall be determined as though the amount to be transferred to the Health

Care Deposit Fund, as referred to in paragraph (2) of subdivision (d), were reduced by 28 percent.

(2) (A) Except as provided in subparagraphs (B), (C), and (D), for the 1993–94 transfer year and subsequent transfer years, transfer amounts shall be increased for the particular transfer year in the amounts necessary to fund the nonfederal share of the total supplemental payment adjustment amounts of all types that arise under Section 14105.98. These increases shall be paid only by those transferor entities that are licensees of hospitals that are projected to receive some or all of the particular supplemental payments, and the increases shall be paid by the transferor entities on a pro rata basis in connection with the particular supplemental payments. For purposes of this paragraph, supplemental payment adjustment amounts shall be deemed to arise for the particular transfer year as of the date specified in Section 14105.98. Transfer amounts to fund the nonfederal share of the payments shall be paid for the particular transfer year within 20 days after the department notifies the transferor entity in writing of the additional transfer amount to be paid.

(B) For the 1995–96 transfer year, the nonfederal share of the secondary supplemental payment adjustments described in paragraph (9) of subdivision (y) of Section 14105.98 shall be funded as follows:

(i) Ninety-nine percent of the nonfederal share shall be funded by a transfer from the University of California.

(ii) One percent of the nonfederal share shall be funded by transfers from those public entities that are the licensees of the hospitals included in the "other public hospitals" group referred to in clauses (ii) and (iii) of subparagraph (B) of paragraph (9) of subdivision (y) of Section 14105.98. The transfer responsibilities for this 1 percent shall be allocated to the particular public entities on a pro rata basis, based on a formula or formulae customarily used by the department for allocating transfer amounts under this section. The formula or formulae shall take into account, through reallocation of transfer amounts as appropriate, the situation of hospitals whose secondary supplemental payment adjustments are restricted due to the application of the limitation set forth in clause (v) of subparagraph (B) of paragraph (9) of subdivision (y) of Section 14105.98.

(iii) All transfer amounts under this subparagraph shall be paid by the particular transferor entities within 30 days after the department notifies the transferor entity in writing of the transfer amount to be paid.

(C) For the 1997–98 transfer year, transfer amounts to fund the nonfederal share of the supplemental payment adjustments described in subdivision (af) of Section 14105.98 shall be funded by a transfer from the County of Los Angeles.

(D) (i) For the 1998–99 transfer year, transfer amounts to fund the nonfederal share of the supplemental payment adjustment amounts arising under subdivision (ah) of Section 14105.98 shall be increased as set forth in clause (ii).

(ii) The transfer amounts otherwise calculated to fund the supplemental payment adjustments referred to in clause (i) shall be increased on a pro rata basis by an amount equal to 28 percent of the amount to be transferred to the Health Care Deposit Fund for the 1999–2000 fiscal year, as referred to in paragraph (2) of subdivision (d).

(3) The department shall prepare preliminary analyses and calculations regarding potential transfer amounts, and potential transferor entities shall be notified by the department of estimated transfer amounts as soon as reasonably feasible regarding any particular transfer year. Written notices of transfer amounts shall be issued by the department as soon as possible with respect to each transfer year. All state agencies shall take all necessary steps in order to supply applicable data to the department to accomplish these tasks. The Office of Statewide Health Planning and Development shall provide to the department quarterly access to the edited and unedited confidential patient discharge data files for all Medi-Cal eligible patients. The department shall maintain the confidentiality of that data to the same extent as is required of the Office of Statewide Health Planning and Development. In addition, the Office of Statewide Health Planning and Development shall provide to the department, not later than March 1 of each year, the data specified by the department, as the data existed on the statewide database file as of February 1 of each year, from all of the following:

(A) Hospital annual disclosure reports, filed with the Office of Statewide Health Planning and Development pursuant to former Section 443.31 of, or Section 128735 of, the Health and Safety

Code, for hospital fiscal years that ended during the calendar year ending 13 months prior to the applicable February 1.

(B) Annual reports of hospitals, filed with the Office of Statewide Health Planning and Development pursuant to former Section 439.2 of, or Section 127285 of, the Health and Safety Code, for the calendar year ending 13 months prior to the applicable February 1.

(C) Hospital patient discharge data reports, filed with the Office of Statewide Health Planning and Development pursuant to former subdivision (g) of Section 443.31 of, or Section 128735 of, the Health and Safety Code, for the calendar year ending 13 months prior to the applicable February 1.

(D) Any other materials on file with the Office of Statewide Health Planning and Development.

(4) Transfer amounts calculated by the department may be increased or decreased by a percentage amount consistent with the Medi-Cal state plan.

(5) For the 1993–94 fiscal year, the transfer amount that would otherwise be required from the University of California shall be increased by fifteen million dollars ($15,000,000).

(6) Notwithstanding any other law, except for subparagraph (D) of paragraph (2), the total amount of transfers required from the transferor entities for any particular transfer year shall not exceed the sum of the following:

(A) The amount needed to fund the nonfederal share of all payment adjustment amounts applicable to the particular payment adjustment year as calculated under Section 14105.98. Included in the calculations for this purpose shall be any decreases in the program as a whole, and for individual hospitals, that arise due to the provisions of Section 1396r-4(f) or (g) of Title 42 of the United States Code.

(B) The amount needed to fund the transfers to the Health Care Deposit Fund, as referred to in subdivision (d).

(7) (A) Except as provided in subparagraphs (B) and (C) and in paragraph (2) of subdivision (j), and except for a prudent reserve not to exceed two million dollars ($2,000,000) in the Medi-Cal Inpatient Payment Adjustment Fund, any amounts in the fund, including interest that accrues with respect to the amounts in the fund, that are not expended, or estimated to be required for expenditure, under Section 14105.98 with respect to a particular

transfer year shall be returned on a pro rata basis to the transferor entities for the particular transfer year within 120 days after the department determines that the funds are not needed for an expenditure in connection with the particular transfer year.

(B) The department shall determine the interest amounts that have accrued in the fund from its inception through June 30, 1995, and, no later than January 1, 1996, shall distribute these interest amounts to transferor entities:

(C) With respect to those particular amounts in the fund resulting solely from the provisions of subparagraph (D) of paragraph (2), the department shall determine by September 30, 1999, whether these particular amounts exceed 28 percent of the amount to be transferred to the Health Care Deposit Fund for the 1999–2000 fiscal year, as referred to in paragraph (2) of subdivision (d). Any excess amount so determined shall be returned to the particular transferor entities on a pro rata basis no later than October 31, 1999.

(D) Regarding any funds returned to a transferor entity under subparagraph (A) or (C), or interest amounts distributed to a transferor entity under subparagraph (B), the department shall provide to the transferor entity a written statement that explains the basis for the particular return or distribution of funds and contains the general calculations used by the department in determining the amount of the particular return or distribution of funds.

(i) (1) For the 1991–92 transfer year, each transferor entity shall pay its transfer amount or amounts to the Controller, for deposit in the fund, in eight equal installments.

(2) (A) Except as provided in subparagraphs (B) and (C), for the 1992–93 transfer year and subsequent transfer years, each transferor entity shall pay its transfer amount or amounts to the Controller, for deposit in the fund, in eight equal installments. However, for the 1997–98 and subsequent transfer years, each transferor entity shall pay its transfer amount or amounts to the Controller, for deposit in the fund, in the form of periodic installments according to a timetable established by the department. The timetable shall be structured to effectuate, on a reasonable basis, the prompt distribution of all nonsupplemental payment adjustments under Section 14105.98, and transfers to the Health Care Deposit Fund under subdivision (d).

(B) For the 1994–95 transfer year, each transferor entity shall pay its transfer amount or amounts to the Controller, for deposit in the fund, in five equal installments.

(C) For the 1995–96 transfer year, each transferor entity shall pay its transfer amount or amounts to the Controller, for deposit in the fund, in five equal installments.

(D) Except as otherwise specifically provided, subparagraphs (A) to (C), inclusive, shall not apply to increases in transfer amounts described in paragraph (2) of subdivision (h) or to additional transfer amounts described in subdivision (o).

(E) All requests for transfer payments, or adjustments thereto, issued by the department shall be in writing and shall include (i) an explanation of the basis for the particular transfer request or transfer activity, (ii) a summary description of program funding status for the particular transfer year, and (iii) the general calculations used by the department in connection with the particular transfer request or transfer activity.

(3) A transferor entity may use any of the following funds for purposes of meeting its transfer obligations under this section:

(A) General funds of the transferor entity.

(B) Any other funds permitted by law to be used for these purposes, except that a transferor entity shall not submit to the Controller any federal funds unless those federal funds are authorized by federal law to be used to match other federal funds. In addition, no private donated funds from any health care provider, or from any person or organization affiliated with the health care provider, shall be channeled through a transferor entity or any other public entity to the fund, unless the donated funds will qualify under federal rules as a valid component of the nonfederal share of the Medi-Cal program and will be matched by federal funds. The transferor entity shall be responsible for determining that funds transferred meet the requirements of this subparagraph.

(j) (1) If a transferor entity does not submit any transfer amount within the time period specified in this section, the Controller shall offset immediately the amount owed against any funds which otherwise would be payable by the state to the transferor entity. The Controller, however, shall not impose an offset against any particular funds payable to the transferor entity where the offset would violate state or federal law.

(2) Where a withhold or a recoupment occurs pursuant to the provisions of paragraph (2) of subdivision (r) of Section 14105.98, the nonfederal portion of the amount in question shall remain in the fund, or shall be redeposited in the fund by the department, as applicable. The department shall then proceed as follows:

(A) If the withhold or recoupment was imposed with respect to a hospital whose licensee was a transferor entity for the particular state fiscal year to which the withhold or recoupment related, the nonfederal portion of the amount withheld or recouped shall serve as a credit for the particular transferor entity against an equal amount of transfer obligations under this section, to be applied whenever the transfer obligations next arise. Should no such transfer obligation arise within 180 days, the department shall return the funds in question to the particular transferor entity within 30 days thereafter.

(B) For other situations, the withheld or recouped nonfederal portion shall be subject to paragraph (7) of subdivision (h).

(k) All transfer amounts received by the Controller or amounts offset by the Controller shall immediately be deposited in the fund.

(*l*) For purposes of this section, the disproportionate share list utilized by the department for a particular transfer year shall be identical to the disproportionate share list utilized by the department for the same state fiscal year for purposes of Section 14105.98. Nothing on a disproportionate share list, once issued by the department, shall be modified for any reason other than mathematical or typographical errors or omissions on the part of the department or the Office of Statewide Health Planning and Development in preparation of the list.

(m) Neither the intergovernmental transfers required by this section, nor any elective transfer made pursuant to Section 14164 or Article 5.17 (commencing with Section 14165.55), shall create, lead to, or expand the health care funding or service obligations for current or future years for any transferor entity, except as required of the state by this section or as may be required by federal law, in which case the state shall be held harmless by the transferor entities on a pro rata basis.

(n) Except as otherwise permitted by state and federal law, no transfer amount submitted to the Controller under this section, and no offset by the Controller pursuant to subdivision (j), shall be

claimed or recognized as an allowable element of cost in Medi-Cal cost reports submitted to the department.

(o) Whenever additional transfer amounts are required to fund the nonfederal share of payment adjustment amounts under Section 14105.98 that are distributed after the close of the particular payment adjustment year to which the payment adjustment amounts apply, the additional transfer amounts shall be paid by the parties who were the transferor entities for the particular transfer year that was concurrent with the particular payment adjustment year. The additional transfer amounts shall be calculated under the formula that was in effect during the particular transfer year. For transfer years prior to the 1993–94 transfer year, the percentage of the additional transfer amounts available for transfer to the Health Care Deposit Fund under subdivision (d) shall be the percentage that was in effect during the particular transfer year. These additional transfer amounts shall be paid by transferor entities within 20 days after the department notifies the transferor entity in writing of the additional transfer amount to be paid.

(p) (1) Ten million dollars ($10,000,000) of the amount transferred from the Medi-Cal Inpatient Payment Adjustment Fund to the Health Care Deposit Fund due to amounts transferred attributable to years prior to the 1993–94 fiscal year is hereby appropriated without regard to fiscal years to the State Department of Health Care Services to be used to support the development of managed care programs under the department's plan to expand Medi-Cal managed care.

(2) These funds shall be used by the department for both of the following purposes: (A) distributions to counties or other local entities that contract with the department to receive those funds to offset a portion of the costs of forming the local initiative entity and (B) distributions to local initiative entities that contract with the department to receive those funds to offset a portion of the costs of developing the local initiative health delivery system in accordance with the department's plan to expand Medi-Cal managed care.

(3) Entities contracting with the department for any portion of the ten million dollars ($10,000,000) shall meet the objectives of the department's plan to expand Medi-Cal managed care with regard to traditional and safety net providers.

(4) Entities contracting with the department for any portion of the ten million dollars ($10,000,000) may be authorized under those contracts to utilize their funds to provide for reimbursement of the costs of local organizations and entities incurred in participating in the development and operation of a local initiative.

(5) To the full extent permitted by state and federal law, these funds shall be distributed by the department for expenditure at the local level in a manner that qualifies for federal financial participation under the Medicaid Program.

(q) (1) Any local initiative entity that has performed unanticipated additional work for the purposes identified in subparagraph (B) of paragraph (2) of subdivision (p) resulting in additional costs attributable to the development of its local initiative health delivery system, may file a claim for reimbursement with the department for the additional costs incurred due to delays in start dates through the 1996–97 fiscal year. The claim shall be filed by the local initiative entity not later than 90 days after the effective date of the act adding this subdivision, and shall not seek extra compensation for any sum that is or could have been asserted pursuant to the contract disputes and appeals resolution provisions of the local initiative entity's respective two-plan model contract. All claims for unanticipated additional incurred costs shall be submitted with adequate supporting documentation including, but not limited to, all of the following:

(A) Invoices, receipts, job descriptions, payroll records, work plans, and other materials that identify the unanticipated additional claimed and incurred costs.

(B) Documents reflecting mitigation of costs.

(C) To the extent lost profits are included in the claim, documentation identifying those profits and the manner of calculation.

(D) Documents reflecting the anticipated start date, the actual start date, and reasons for the delay between the dates, if any.

(2) In determining any amount to be paid, the department shall do all of the following:

(A) Conduct a fiscal analysis of the local initiative entity's claimed costs.

(B) Determine the appropriate amount of payment, after taking into consideration the supporting documentation and the results of any audit.

(C) Provide funding for any such payment, as approved by the Department of Finance through the deficiency process.

(D) Complete the determination required in subparagraph (B) within six months after receipt of a local initiative entity's completed claim and supporting documentation. Prior to final determination, there shall be a review and comment period for that local initiative entity.

(E) Make reasonable efforts to obtain federal financial participation. In the event federal financial participation is not allowed for this payment, the state's payment shall be 50 percent of the total amount determined to be payable.

(r) Notwithstanding any other law, the Controller may use the moneys in the Medi-Cal Inpatient Payment Adjustment Fund for loans to the General Fund as provided in Sections 16310 and 16381 of the Government Code. However, interest shall be paid on all moneys loaned to the General Fund from the Medi-Cal Inpatient Payment Adjustment Fund. Interest payable shall be computed at a rate determined by the Pooled Money Investment Board to be the current earning rate of the fund from which loaned. This subdivision does not authorize any transfer that will interfere with the carrying out of the object for which the Medi-Cal Inpatient Payment Adjustment Fund was created.

SEC. 2. Article 5.17 (commencing with Section 14165.55) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 5.17. Nondesignated Public Hospital Medi-Cal Rate Stabilization Act

14165.55. For the purposes of this article, the following definitions shall apply:

(a) "Bad debt charges" means deductions from revenue for bad debt.

(b) "Charity care charges" means deductions from revenue for charity care.

(c) "Contract Hospital" means a nondesignated public hospital, which has a Medi-Cal fee-for-service contract negotiated by the California Medical Assistance Commission in effect as of December 31 of the applicable state fiscal year.

(d) "Contract Hospital allocation" means the portion of the Nondesignated Public Hospital IGT Pool that is allocated to and transferred to the state by the transferring entity on behalf of the contract hospitals.

(e) "Converted hospital" means a private hospital that becomes a designated public hospital or a nondesignated public hospital on or after July 1 of any state fiscal year, a nondesignated public hospital that becomes a private hospital or a designated public hospital on or after July 1 of any state fiscal year, or a designated public hospital that becomes a private hospital or a nondesignated public hospital on or after July 1 of any state fiscal year. A hospital shall be considered a converted hospital only for the fiscal year during which it became a converted hospital.

(f) "Intergovernmental transfer (IGT)" means the transfer of public funds by the public entity to the state in accordance with the requirements of this section.

(g) "Intergovernmental transfer allocation" or "IGT allocation" means the amount of the Nondesignated Public Hospital IGT Pool allocated to a nondesignated public hospital for a state fiscal year. Each transferring entity may agree to transfer its IGT allocation to the state in order to participate in the Nondesignated Public Hospital Intergovernmental Transfer Program in accordance with this section and Section 14164.

(h) "Intergovernmental transfer formula group" or "IGT formula group" means any of the following groups:

(1) Contract Hospitals that have an IGT Formula Score of between seven and nine, inclusive.

(2) Contract Hospitals that have an IGT Formula Score of between four and six, inclusive.

(3) Contract Hospitals that have an IGT Formula Score of between one and three, inclusive.

(4) Non-Contract Hospitals that have an IGT Formula Score of between seven and nine, inclusive.

(5) Non-Contract Hospitals that have an IGT Formula Score of between four and six, inclusive.

(6) Non-Contract Hospitals that have an IGT Formula Score of between one and three, inclusive.

(i) "New nondesignated hospital" means a hospital that was not in operation under current or prior ownership as a nondesignated public hospital for any portion of the calendar year prior to July 1

of any state fiscal year. A hospital shall be considered a new hospital only for the fiscal year during which it began operating.

(j) "Non-Contract Hospital" means a nondesignated public hospital, which does not have a Medi-Cal fee-for-service contract negotiated by the California Medical Assistance Commission in effect as of December 31 of the applicable state fiscal year.

(k) "Non-Contract Hospital allocation" means the portion of the Nondesignated Public Hospital IGT Pool that is allocated to and transferred to the state by the transferring entity on behalf of the Non-Contract Hospitals.

(*l*) "Nondesignated public hospital" means either of the following:

(1) A public hospital that is licensed under subdivision (a) of Section 1250 of the Health and Safety Code, is not designated as a specialty hospital in the hospital's latest annual Office of Statewide Health Planning and Development (OSHPD) financial disclosure report for the hospital, and satisfies the definition in paragraph (25) of subdivision (a) of Section 14105.98, excluding designated public hospitals, as described in subdivision (d) of Section 14166.1 as that section may be amended from time to time.

(2) A tax-exempt nonprofit hospital that is licensed under subdivision (a) of Section 1250 of the Health and Safety Code, is not designated as a specialty hospital in the hospital's latest annual OSHPD financial disclosure report, is a hospital operated, owned, or both by a local health care district, and is affiliated with the health care district hospital owner by means of the district's status as the nonprofit corporation's sole corporate member.

(m) "Nondesignated Public Hospital Intergovernmental Transfer Pool" or "Nondesignated Public Hospital IGT Pool" means the pool of funds that will be utilized as the state's share of the aggregate payments funded by the transferring entity's intergovernmental transfers for a state fiscal year. This amount shall be calculated based on the room under the federal Upper Payment Limit (UPL) in the category of Non-State Government Owned Hospitals (Inpatient) which the department has determined is both attributable to the nondesignated public hospitals and available for the purposes of this article as determined by the department pursuant to Section 14165.56.

(n) "Public entity" means the transferring entity, which may be a city, county, special purpose district, or other governmental unit

in the state, regardless of whether the unit of government is also a health care provider, except as prohibited by federal law.

(o) "Transferring entity" means a public entity that transfers public funds to the state in accordance with subdivision (f) of Section 14165.57 and is a public entity as defined in subdivision (n).

(p) "Upper payment limit" or "UPL" means the federal upper payment limit category as defined in Sections 447.272 and 447.321 of Title 42 of the Code of Federal Regulations for the amount of the Medicaid payments for which federal financial participation is available for a class of service and a class of health care providers.

14165.56. (a) The department shall establish, implement, and maintain the Nondesignated Public Hospital Intergovernmental Transfer Program to provide supplemental payments to nondesignated public hospitals in a manner that maximizes federal financial participation in the resulting supplemental payments. The department shall develop and implement the program subject to receiving all federal approvals.

(b) Upon receiving federal approval, the department shall fully implement this section beginning with the 2010–11 fiscal year. The department shall perform all acts necessary to secure the maximum level of federal financial participation for payments resulting from the Nondesignated Public Hospital IGT Pool. The department shall make every effort to implement this section for the 2010–11 fiscal year so that all allocations will be determined, all intergovernmental transfers will be received by the state, and federal financial participation will be drawn in order for the department to make payments due to each nondesignated public hospital prior to July 1, 2011.

(c) By August 1 of each fiscal year, beginning with the 2011–12 fiscal year and every year thereafter, the department shall provide an estimate of the Non-State Government Owned Hospital (Inpatient) UPL associated with the inpatient fee-for-service payments to nondesignated public hospitals in order to establish both the UPL and the available room in the UPL. The department may make supplemental inpatient fee-for-service payments to nondesignated public hospitals using some or all of the shortfall level below the UPL. The amount identified by the department as available for those payments shall be multiplied by 100 percent

minus the annual federal matching assistance percentage, as defined in Part 433 of Title 42 of the Code of Federal Regulations and shall be the amount available in the Nondesignated Public Hospital Intergovernmental Transfer Pool. The payments made pursuant to this article may be funded using public entity intergovernmental transfers and associated federal financial participation.

(d) Once the department has estimated the UPL and the potential supplemental payment relating to nondesignated public hospitals, the department shall use the IGT allocation formula described in Section 14165.57 to determine the estimated IGT allocation for each nondesignated public hospital from the Nondesignated Public Hospital IGT Pool using the most recent data publicly available from the federal Centers for Medicare and Medicaid Services (CMS), and the federal Health Resources and Services Administration (HRSA).

14165.57. (a) The IGT allocation formula shall use data from each nondesignated public hospital's latest Hospital Annual Financial Disclosure Report on file with OSHPD as of March 1 of each prior fiscal year and shall be as follows:

(1) The Nondesignated Public Hospital IGT Pool shall be allocated into two allocations: the Contract Hospitals allocation and the Non-Contract Hospitals allocation. This allocation shall be made to each group, respectively, based upon the ratio of Medi-Cal fee-for-service acute patient days listed in the latest OSHPD Annual Financial Disclosure Report for Contract Hospitals and Non-Contract Hospitals to the total Medi-Cal fee-for-service acute patient days provided by all Contract Hospitals and Non-Contract Hospitals. Medi-Cal fee-for-service acute patient days for converted hospitals and new hospitals will not be included in this allocation.

(2) The department shall determine if a nondesignated public hospital provides services in either a federally recognized Health Professional Shortage Area or to a federally recognized Medically Underserved Area or Population. The department shall also determine if the nondesignated public hospital is federally recognized as either a Critical Access Hospital or a Sole Community Provider. If any of these conditions apply, the hospital shall score one point. Otherwise, the hospital shall score zero points.

(3) The department shall calculate for each nondesignated public hospital the charity care charges as a percentage of the hospital's total gross revenue. If the charity care charges are greater than or equal to 3 percent of the total gross revenue, the hospital shall score three points. If the charity care charges are less than 3 percent, but more than or equal to 1 percent, of the total gross revenue, the hospital shall score two points. If the charity care charges are less than 1 percent, but greater than 0 percent, of the total gross revenue, the hospital shall score one point. If charity care charges are less than or equal to 0 percent, of the total gross revenue, the hospital shall score zero points.

(4) The department shall calculate for each nondesignated public hospital the bad debt charges as a percentage of the hospital's other payer's gross revenue, as disclosed in the Hospital Annual Financial Disclosure Report. If the bad debt charges are greater than or equal to 40 percent of the other gross revenue, the hospital shall score two points. If the bad debt charges are less than 40 percent, but greater than 0 percent, of the other gross revenue, the hospital shall score one point. If the bad debt charges are less than or equal to 0 percent, of the other gross revenue, the hospital shall score zero points.

(5) The department shall calculate for each nondesignated public hospital the Medi-Cal charges as a percentage of the hospital's total gross revenue. If the Medi-Cal charges are greater than or equal to 25 percent of the total gross revenue, the hospital shall score three points. If the Medi-Cal charges are less than 25 percent, but more than or equal to 12 percent, of the total gross revenue, the hospital shall score two points. If the Medi-Cal charges are less than 12 percent, but greater than 0 percent, of the total gross revenue, the hospital shall score one point. If the Medi-Cal charges are less than or equal to 0 percent of total gross revenue, the hospital shall score zero points.

(6) The sum of each nondesignated public hospital's points accumulated pursuant to paragraphs (2) to (5), inclusive, shall constitute the hospital's IGT Formula Score. The IGT Formula Score for a new hospital or a converted hospital shall be equal to zero.

(7) The Contract Hospital allocation shall be allocated among Contract Hospitals and the Non-Contract Hospital allocation shall

be allocated among Non-Contract Hospitals to determine preliminary allocations in accordance with the following:

(A) Each Contract Hospital that has an IGT Formula Score of between seven and nine, inclusive, shall be allocated three times the amount of the Contract Hospital allocation that is allocated to each Contract Hospital that has a score of one to three, inclusive.

(B) Each Contract Hospital that has an IGT Formula Score of between four and six, inclusive, shall be allocated two times the amount of the Contract Hospital allocation that is allocated to each Contract Hospital that has an IGT Formula Score of one to three, inclusive.

(C) Each Non-Contract Hospital that has an IGT Formula Score of between seven and nine, inclusive, shall be allocated three times the amount of the Non-Contract Hospital allocation that is allocated to each Non-Contract Hospital that has an IGT Formula Score of one to three, inclusive.

(D) Each Non-Contract Hospital that has an IGT Formula Score of between four and six, inclusive, shall be allocated two times the amount of the Non-Contract Hospital allocation that is allocated to each Non-Contract Hospital that has an IGT Formula Score of one to three, inclusive.

(E) No amount shall be allocated to a nondesignated public hospital with an IGT Formula Score of zero points.

(8) The sum of the preliminary allocation determined under paragraph (7) for all hospitals within each IGT Formula Group shall be reallocated among the hospitals within each IGT Formula Group based on the ratio of each hospital's staffed acute beds listed in the latest OSHPD Annual Financial Disclosure Report, to the total staffed acute beds of all hospitals in the IGT Formula Group.

(b) By no later than September 1 of the 2011–12 fiscal year or as soon thereafter as federal approvals are obtained, and by no later than September 1 of each fiscal year thereafter, the department shall provide each nondesignated public hospital with an estimated IGT allocation notice that includes the calculations and data sources used to calculate the estimated IGT allocation, as described in this section.

(c) Each nondesignated public hospital shall have 30 days from receipt of the estimated IGT allocation notice from the department to review the department's hospital-specific estimated IGT allocation and to notify the department of any data or calculation

errors. If the hospital does not respond within 30 days, the information will be deemed accurate. No later than November 30 of each fiscal year, the department shall incorporate all appropriate corrections or data updates for all of the nondesignated public hospitals and then recalculate the IGT allocations using the IGT allocation formula to obtain a final IGT allocation for each nondesignated public hospital.

(d) Beginning with the 2011–12 fiscal year, on or before December 1 or as soon thereafter as federal approvals are obtained, and by no later than December 1 of each fiscal year thereafter, the department shall send each nondesignated public hospital a notice of eligibility indicating the final IGT allocation for the nondesignated public hospital. The nondesignated public hospital shall have 20 business days after receipt of the notice to either accept or decline the offer. If a nondesignated public hospital accepts the offer, the nondesignated public hospital may enter into an IGT agreement with the department. If the department receives no response, the offer will be considered declined.

(e) Before the later of December 31 of the 2011–12 fiscal year, the date upon which all federal approvals are obtained, and by no later than January 15 of each state fiscal year thereafter, the department shall document all nondesignated public hospital IGT allocation offers that are either accepted or declined. After the department has recorded all IGT allocations as being either accepted or declined, any remaining unsubscribed IGT allocations will be allocated to all the other participating nondesignated public hospitals on a pro rata basis based on the final IGT allocations calculated pursuant to subdivision (b) during January of each fiscal year. The department shall inform each nondesignated public hospital participating in the program of the revised final IGT allocation assigned to that hospital by January 30. At that time, the department shall give each nondesignated public hospital participant five days to accept or decline participation in the program.

(f) The state may accept all public funds in the amount of the final IGT allocation from a transferring entity pursuant to this section, provided that any funds from a transferring entity must be permitted by law to be used for these purposes. The transferring entity shall certify to the department that the funds it proposes to

transfer satisfy the requirements of this subdivision, and are in compliance with all federal rules and regulations.

(g) The state shall deposit the funds received from the transferring entities pursuant to this article into the Medi-Cal Inpatient Payment Adjustment Fund established in accordance with Section 14163.

(h) Nondesignated public hospital participating in the program shall inform the public entity funding the IGT to transfer the appropriate IGT allocation, by February 5 of each fiscal year, to the state according to the time schedule specified in the written agreement specified in subdivision (d). By March 31 of each fiscal year, the department shall make the supplemental payment to the nondesignated public hospital including the associated federal financial participation. The deadlines set forth in this subdivision shall be implemented beginning with the 2011–12 fiscal year or as soon thereafter as federal approvals are obtained.

(i) The department shall establish written policies and procedures for transferring entity intergovernmental transfers and payments made to nondesignated public hospitals pursuant to this section. The department shall effectively communicate these policies and procedures to nondesignated public hospitals and the public entities that will be funding the IGTs in order to facilitate a smooth process using local public entity moneys for purposes of drawing down federal financial participation for supplemental payments to nondesignated public hospitals.

(j) The state shall retain 9 percent of each IGT amount to reimburse the department, or transfer to the General Fund, for the administrative costs of operating the Nondesignated Public Hospital Intergovernmental Transfer Program and for the benefit of Medi-Cal children's health care programs.

(k) Participation in the intergovernmental transfers under this article is voluntary on the part of the transferring entities for the purpose of all applicable federal laws.

(*l*) (1) The department shall report annually to the Legislature on the Nondesignated Public Hospital Intergovernmental Transfer Program. This report shall include, but not be limited to, the amount of funds available within the UPL, the total amount of IGT allocation funds transferred by public entities, the total amount of federal financial participation received by nondesignated public hospitals, and information on the effectiveness of the IGT

allocation formula to distribute available federal matching funds among participating nondesignated public hospitals.

(2) The requirement for submitting a report to the Legislature on the Nondesignated Public Hospital Intergovernmental Transfer Program imposed under paragraph (1) is inoperative four years after the date the first report is due.

(3) A report to be submitted pursuant to paragraph (1) shall be submitted in compliance with Section 9795 of the Government Code.

(m) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this article by means of policy letters or similar instructions, without taking further regulatory action.

SEC. 3. There is hereby appropriated to the State Department of Health Care Services the following sums for the purposes specified in subdivisions (b) and (c) of Section 14168.33 of the Welfare and Institutions Code to be available for expenditure until January 1, 2014:

(a) The sum of one billion five hundred million dollars ($1,500,000,000) from the Hospital Quality Assurance Revenue Fund.

(b) The sum of one billion five hundred million dollars ($1,500,000,000) from the Federal Trust Fund.

SEC. 4. This act shall become operative only if Senate Bill 90 of the 2011–12 Regular Session of the Legislature is enacted and becomes effective.

SEC. 5. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make the necessary statutory changes to increase Medi-Cal payments to hospitals and improve access at the earliest possible time, so as to allow this act to be operative as soon as approval from the federal Centers for Medicare and Medicaid Services is obtained by the State Department of Health Care Services, it is necessary that this act take effect immediately.

Approved _____, 2011

_____

Governor